MAGELLAN MEDICAID ADMINISTRATION

# Kentucky Medicaid Pharmacy Provider Manual

## Long Term Care Supplement

Version 1.3

June 23, 2010

# HIPAA Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] and the American Recovery and Reinvestment Act (ARRA) of 2009 provides protection for personal health information. Magellan Medicaid Administration developed and maintains HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandates.

Protected health information (PHI) includes any health information and confidential information, whether verbal, written, or electronic, created, received, or maintained by Magellan Medicaid Administration. It is health care data plus identifying information that would allow the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

# Revision History

| Document Version | Date | Name | Comments |
|---|---|---|---|
| 1.0 | 12/04/2004 | FHSC Kentucky Pharmacy | Initial creation of document |
| 1.1 | 07/01/2007 | FHSC Kentucky Pharmacy | Revised |
| 1.2 | 09/26/2007 | FHSC Kentucky Pharmacy | Section 2.2.1 Added |
| 1.3 | 06/23/2010 | Kentucky Provider Relations; Documentation Mgmt. Team | Updated for name change |
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# 1.0 Introduction

This document is a Supplement to the Magellan Medicaid Administration *Pharmacy Provider Manual*, previously distributed, and is intended to provide additional guidelines for providers who service Long Term Care (LTC) Kentucky Medicaid members.

Providers began submitting claims through Magellan Medicaid Administration on December 4, 2004. Unisys Point-of-Sale (POS) processing was terminated at 7:15 p.m., ET on Friday December 3, 2004; Direct-Data-Entry (DDE) processing was terminated at 3:00 p.m., ET on Friday December 3, 2004.

**Magellan Medicaid Administration will process all claims received on or after December 4, 2004, regardless of the date of service, under the guidelines established by the Kentucky Department for Medicaid Services.**

# 2.0 Long Term Care Processing

## 2.1 Identifying LTC Members

Providers should enter Patient Location Code (NCPDP Field #307-C7) = "3" (Nursing Home) in order to identify that the patient is in a Long-Term-Care (LTC) facility.

## 2.2 Dispensing Limits

- Partial fill transactions are subject to a pro-rated dispense fee.
- Also, as stipulated in Title 21 Code of federal regulations, LTC providers may fill Schedule II, III, or IV substances in partial quantities. When LTC providers partial fill a Schedule II, III, or IV substance within a month, the Kentucky reimbursement regulations regarding dispensing fees apply to the additional partial fills.
- Refer to the Provider Manual (Section 3.1) for 3-brand drug allowance information.
- Exception to the four prescription rule may be made for "Nursing Facility residents that are not Part D eligible." See Provider Notice #022 (or the most recent Provider Notice addressing the four script limit) on the Kentucky pharmacy website: http://kentucky.fhsc.com/pharmacy/providers/bulletins.asp.

### 2.2.1 LTC Partial Fills for Schedule II, III, and IV Drugs

When pharmacies submit claims at point of sale to the Kentucky Department for Medicaid Services for long term care members obtaining Schedule II, III, and IV drugs, use partial fills throughout the month (approximately 28 days). The partial dispense fee process works best when there are 4 partial fills per unique prescription number over the course of 28 days. Dispense fees paid on partial fills of these drugs will be paid at the normal rate ($5.00 generic or $4.50 brand) when there are 4 partials per month. The fields listed below should be used in the completion of those partial fill claims.

**Patient Location** (NCPDP Field #307-C7) = 03

**New/Refill** = "00"

- This field is entered differently for partial fills than all other prescriptions.
- Always enter "00" for each of the 4 partial fills per month.

**Quantity Dispensed** (NCPDP FIELD #442-E7)

- Number dispensed for that partial fill's time period

**Days Supply** (NCPDP FIELD #405-D5)

- Number of days for which Quantity Dispensed for that partial fill

**Dispensing Status** (NCPDP Field #343-HD)

- P (partial fill) or C (completion of partial fill)
- This is an alpha field only.
- "P" is entered on all partials except the final one; "C" is entered on the last partial of the prescription.

**Days Supply Intended to be Dispensed** (NCPDP Field #345-HG)

- This is a numeric field only.
- This is the total number of days "intended" for the entire prescription.
- If this field is populated, **Quantity Intended to be Dispensed** must also be populated.
- Take **Days Supply** (from above) and multiply by number of partials in month.
  **Example:**
  Days Supply of 7 x 4 partials in month = 28 Days Supply Intended to be Dispensed

**Quantity Intended to be Dispensed** (NCPDP Field #344-HF)

- This is a numeric field only.
- This is the total quantity "intended" to be dispensed for the entire prescription.
- If this field is populated, **Days Supply Intended to be Dispensed** must also be populated.
- Take **Quantity Dispensed** (from above) and multiply by number of partials in month.
  **Example:**
  Quantity Dispensed 21 x 4 partials in month = 84 Quantity Intended to be Dispensed

**Associated Prescription Date** (NCPDP Field #457-EP)

- Leave this "associated" field blank on Partial #1.
- For all other partial fills of a prescription, use the original prescription date from Partial #1 as the **Associated Prescription Date**.
- This field must be populated using the CCYYMMDD format where:
  - C = Century
  - Y = Year
  - M = Month
  - D = Day

**Associated Prescription Reference Number** (NCPDP Field #456-EN)

- Leave this "associated" field blank on Partial #1

- For all other partial fills of a prescription, use the original prescription number from Partial #1 as the Associated Prescription Reference Number.

If you have any questions regarding this, please contact the Magellan Medicaid Administration Technical Call Center at 800-432-7005.

## 2.3 Generic Requirements

Generic requirements for LTC members are the same as for ambulatory members. These requirements are detailed in the *Pharmacy Provider Manual* (Section 3.2).

## 2.4 Maximum Allowable Cost (MAC) Program

The Maximum Allowable Cost (MAC) Program is applicable to LTC members. These requirements are detailed in the *Pharmacy Provider Manual* (Section 3.3).

## 2.5 Drug Coverage

- General drug coverage for LTC members is the same as for ambulatory members with the noted exception below.

The Kentucky Department for Medicaid Services has identified drugs that are not covered for LTC members or separate reimbursement through the Pharmacy benefit, as these drugs are considered covered in the LTC "per diem" reimbursement. These drugs are categorized as "comfort" drugs; the list as of November 30, 2004 follows.

**The Kentucky Department for Medicaid Services began denying LTC claims for these products on January 5, 2005. Prior to that date, covered rebatable drugs paid (if all other edits are met) for LTC without prior authorization.**

- Aluminum/Magnesium Hydroxide Suspension
- Concentrated Aluminum/Magnesium Hydroxide Suspension
- Aluminum/Magnesium Hydroxide+Simethicone Suspension
- Concentrated Aluminum/Magnesium Hydroxide+Simethicone Suspension
- Kaolin/Pectin Suspension
- Kaolin/Pectin w/ Belladonna Alkaloids Suspension
- Bismuth Subsalicylate Suspension
- Docusate Sodium 100mg Capsule
- Milk of Magnesia
- Mineral Oil
- Bisacodyl 5mg TAB

- Milk of Magnesia w/ Cascara Sagrada
- Guaifenesin Syrup
- Acetaminophen 325mg Tablet
- Aspirin 650mg Compressed Tablet
- Acetaminophen 650mg Suppositories or Aspirin 650mg Suppositories
- Acetaminophen 160mg/5ml Elixir
- Isopropyl Alcohol 70%
- Hydrogen Peroxide 10%
- Neomycin/Polymicin/Bacitracin Topical Ointment
- Povidone Iodine Solution
- Topical Skin Moisturizing Lotion
- Mouthwash

## 2.6 Member Payment Information

There is no pharmacy co-payment for LTC members who are placed in the Comprehensive Choice benefit package.

## 2.7 Prior Authorization

Medications requiring Prior Authorization are noted on the Preferred Drug List which is posted on the Kentucky pharmacy website: https://kentucky.fhsc.com/Pharmacy/Providers/DrugInfo.asp.

## 2.8 Emergency Procedures (Prior Authorization)

- All providers should follow normal prior authorization procedures, except in emergency conditions.
- The emergency override is intended for unique circumstances where general prior authorization procedures cannot be followed and the situation is considered life threatening.
- Providers may override PA Requirements by entering LEVEL OF SERVICE (NCPDP Field #418-DI) – “3” (emergency) under the following guidelines:
  - Overrides must be outside of normal business hours.
  - Overrides must be for a 3-day supply except where the package must be dispensed intact.
  - OTCs cannot be overridden.
  - Drugs normally not covered cannot be overridden.

## 2.9 Medicare Covered Drugs

- Medicare Part B and Part D drugs will not be covered by the Kentucky Department for Medicaid Services. These claims will deny with NCPDP Error Code 41 and the supplemental message of "Submit bill to other process or primary payer." Medicare Part D claims will return an additional message of "Bill Medicare Part D; Other payer not cost avoided."
- Crossover billing is not part of the POS system.
- **Medicare Part D**
  - On the date that Kentucky Medicaid members become eligible for Medicare Part D, the Kentucky Department for Medicaid Services will only cover three classes of drugs for these dual-eligible individuals:
    - Over-the-Counter Medications (OTCs)
    - Benzodiazepines
    - Barbiturates

(And a few other miscellaneous products not covered by Part D)

## 2.10 Compounds or Home IV

- Method of Submission (since 2/1/05) for Compound Prescription – **Must use Multi-Ingredient Compound Segment**:
  - On the Product/Service screen, enter 11 zeros (00000000000) in the Product/Incoming ID/NDC field
  - Enter the Compound Code of "2"
- On the Compound screen, enter NDCs of all ingredients on one claim, using one Rx number

# 3.0 Prospective Drug Utilization Review (ProDUR)

Prospective Drug Utilization Review (ProDUR) encompasses the detection, evaluation, and counseling components of pre-dispensing drug therapy screening. The ProDUR system of Magellan Medicaid Administration assists the pharmacist in these functions by addressing situations in which potential drug problems may exist. ProDUR performed prior to dispensing helps pharmacists ensure that their patients receive appropriate medications. This is accomplished by providing information to the dispensing pharmacist that may not have been previously available.

Because Magellan Medicaid Administration's ProDUR system examines claims from all participating pharmacies, drugs that interact or are affected by previously dispensed medications can be detected. Magellan Medicaid Administration recognizes that the pharmacist uses his/her education and professional judgment in all aspects of dispensing. ProDUR is offered as an informational tool to aid the pharmacist in performing his/her professional duties.

## 3.1 Therapeutic Problems

Prospective (concurrent) Drug Utilization Review edits will be returned as "alert messages" for LTC members. At the determination of the Kentucky Department for Medicaid Services, this is subject to change to hard denials requiring provider-level or call center overrides. Providers will be notified in a timely manner.

# 4.0 Provider Reimbursement

## 4.1 Provider Payment Algorithm

- The provider is paid at the lesser of:
  - AWP - 14% for generic + dispense fee
  - AWP – 15% for brand + dispense fee
  - FUL + dispense fee
  - MAC + dispense fee
  - Usual and Customary
  - Gross Amount Due

### Unit Dose Repackaging

Providers will be reimbursed $.02 cents per unit for repackaging products into unit-dose packaging. Providers are eligible for this fee for solid-dosage forms only for those products not packaged as unit-dose by the manufacturer. Providers should indicate pharmacy repackaging by entering a UNIT DOSE INDICATOR (NCPDP Field #429-DT) = "03" and the appropriate amount in the INCENTIVE AMOUNT SUBMITTED field (NCPDP Field #438-E3). The cap is $25.00 per Rx.

### Return to Stock (RTS)

- Providers should return to stock any unused portion of unit-dose packaged medications. In order to process the return accurately, providers should either:
  - Submit a Re-bill (B3 transaction) with the actual quantity dispensed, or
  - Reverse the original claim (B2 transaction) and submit a new claim (B1 transaction) with the actual quantity dispensed.
- Providers will be entitled to the full dispense fee on RTS claims.
- Providers will be entitled to the unit dose/repackaging fee only for the actual quantity dispensed on RTS claims.

When a provider needs to return all of the medications to stock, to retain the dispense fees, the provider should submit the claim with a value of ".001" as the quantity.

## 4.2 Provider Dispensing Fees

- The dispense fee is $4.50 for Brand or $5.00 for Generic.
- Guidelines regarding dispense fees are included in the Kentucky State Regulations under 907 KAR 1:018 Reimbursement for Drugs.